MDR Tracking Number: M5-04-0445-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 10-13-03.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visit/outpatient, radiologic exam spine lumbosacral, application modalities, therapeutic procedures, myofascial release, manipulation (separate procedure performed by PH) on 06-16-03 through 07-07-03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 06-16-03 through 07-07-03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 13th day of January 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

January 11, 2004

Re: IRO Case # M5-04-0445

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Anesthesiology and Pain Management, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History
The patient is a 30-year-old male who has had low back since a ___ injury. Physical therapy and chiropractic care were provided after the injury. The patient was treated with similar modalities 6/16/03-7/7/03

Requested Service(s)
Office/outpt. Rad exam spine lumbosacral, application modalities, therapeutic procedures, myofascial release, manipulation, (separate proc) performed by PH 6/16/03-7/7/03

Decision
I agree with the carrier's decision to deny the requested services.

Rational
It was not reasonable or necessary to repeat passive modalities six months after injury (either prior to injection or post injection) when similar measures utilized the first month after injury were not effective.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.